

Anesthesia Adverse Events Annual Report U.C.A. § 26-1-40

Center for Health Data and Informatics

BACKGROUND

In the 2017 Legislative year, HB 142 Anesthesia Amendment was passed which requires healthcare providers licensed under the Utah Code, Division of Professional Licensing (DOPL) Title 58 (Sections 58-5a-502 (Podiatrists), 58-31b-502.5 (Nurses & Nurse Practitioners), 58-67-502.5 (Physicians and Surgeons), 58-68-502.5 (Osteopaths) and 68-69-502.,5 (Dentists and Dental Hygienists) to report IV sedation related adverse events that occur in the outpatient setting (non-Hospital and non-Ambulatory Surgical Centers) to the Utah Department of Health. If a provider does not report these events, the DOPL law change has determined that "non-reporting" to be considered unprofessional conduct with subsequent consequences.

Over the 2017 summer, an interdisciplinary team of healthcare professionals (Podiatrists, Nurses, Certified Registered Nurses of Anesthetics, Anesthesiologists, Physicians and Surgeons, Dentists, Osteopaths and others) met to determine the rule set needed to operationalize HB 142. A set of administrative rules were filed and published for public comment with one change and have become effective April 14, 2018.

An online reporting database was developed to receive reports using REDCAP technology The Patient Safety web site was updated to include the law and rules related to how to report. Effective date for reporting to begin was set at July 1, 2018.

In spring of 2018 close to 15,000 providers were notified of the reporting requirement and procedures via email and 12,000 in a hard copy letter. In fall of 2019 close to 54,441 providers were notified of the reporting requirement and procedures via email and in spring of 2020, 9,525 providers were notified in a hard copy letter.

Several phone calls were received asking for clarification of the reporting requirements. Most of these questions were related to clarifying reporting requirements from those who work in hospitals and ambulatory surgical centers versus outpatient settings. Hospital and Ambulatory Surgical Centers are covered under the Patient Safety Rule R 380-200. The law and rules apply to outpatient settings only.

There have only been five complete reports of an adverse event since the effective date. General information about the reports is below.



ADVERSE EVENTS DATA

One death and one adverse event have been reported from July 1, 2018 through June 30, 2019.

Reporting Category	Patient 1	Patient 2
Event type	Death	Loss of consciousness and
		breathing. Temporary harm
		required hospitalization.
Type of health care provider	General Dentist	Dentist
License category of person	CRNA	Doctor or Dental Surgery
submitting report		
Specialty of person submitting	Certified registered nurse anesthetist	Dentist
report		
Person who administered	Certified registered nurse anesthetist	Dentist
sedation or anesthesia		
Proceduralist specialty	General Dentist	Doctor or Dental Surgery
Proceduralist license type	Other	Dentist
Type of facility in which the	Anesthesia administered at dental	Physician's Office
death or adverse event took	clinic, death occurred several hours	
place	later at a hospital	

Three adverse events have been reported from July 1, 2019 through June 10, 2020

Reporting Category	Patient 1	Patient 2	Patient 3
	Seizure like	Transported to ER	Patient slow to wake up
	activities.	for evaluation of	after sedation. Rescue
	Transported to ER.	potential MI.	or reversal agent used.
	On arrival at the ER,	Patient was	
	seizure like activity	released after MI	
	resolved. Released	was ruled out.	
	from ER after		
Event Type	monitoring.		
Type of health care provider	Dentist	Dentist	Medical Doctor
License category of person			
submitting report	DDS	DMD	N/A
Specialty of person submitting			
report	Oral Surgeon	Oral Surgeon	Clinic Manager
Person who administered			
sedation or anesthesia	Dentist	Dentist	Nurse
Proceduralist specialty	Oral Surgeon	Oral Surgeon	OBGYN
Proceduralist license type	DDS	DMD	Physician and Surgeon
Type of facility in which the death		Ambulatory	
or adverse event took place	Oral Surgery Office	Surgical Center	Physician's Office